BEFORE THE BOARD OF MEDICAL EXAMINERS

IN THE STATE OF ARIZONA

In the Matter of **BRUCE C. HUNTER, M.D.** Holder of License No. 24075 For the Practice of Medicine In the State of Arizona.	Case No. MD-00-0370, MD-00-0546, MD-01-0455, MD-01-0687 **CONSENT AGREEMENT FOR A DECREE OF CENSURE AND PROBATION**

CONSENT AGREEMENT

By mutual agreement and understanding, between the Arizona Board of Medical Examiners ("Board") and Bruce C. Hunter, M.D. ("Respondent"), the parties agreed to the following disposition of this matter at the Board's public meeting on March 6, 2002.

1. Respondent acknowledges that he has read and understands this Consent Agreement and the stipulated Findings of Fact, Conclusions of Law and Order. Respondent acknowledges that he understands he has the right to consult with legal counsel regarding this matter and has done so or chooses not to do so.

2. Respondent understands that by entering into this Consent Agreement for the issuance of the foregoing Order, he voluntarily relinquishes any rights to a hearing or judicial review in state or federal court on the matters alleged, or to challenge this Consent Agreement and the Order in its entirety as issued by the Board, and waives any other cause of action related thereto or arising from said Order.

3. Respondent acknowledges and understands that this Consent Agreement and the Order will not become effective until approved by the Board and signed by its Executive Director.

4. All admissions made by Respondent are solely for final disposition of this matter and any subsequent related administrative proceedings or civil litigation involving the Board and Respondent. Therefore, said admissions by Respondent are not intended or made for any other use, such as in the context of another state or federal government regulatory agency proceeding, civil or criminal court proceeding, in the State of Arizona or any other state or federal court.

5. Respondent acknowledges and agrees that, although the Consent Agreement has not yet been accepted by the Board and issued by the Executive Director, upon signing this agreement, and returning this document (or a copy thereof) to the Board's Executive Director, Respondent may not revoke his acceptance of the Consent Agreement and Order. Respondent may not make any modifications to the document. Any modifications to this original document are ineffective and void unless mutually approved by the parties.

6. Respondent further understands that this Consent Agreement and Order, once approved and signed, shall constitute a public record document that may be publicly disseminated as a formal action of the Board.

7. If any part of the Consent Agreement and Order is later declared void or otherwise unenforceable, the remainder of the Order in its entirety shall remain in force and effect.

Bruce C. Hunter, M.D.

Reviewed and accepted this 5th day of FEBRUARY, 2002.

Dan Jantsch, Esq.
(Counsel for Bruce Hunter, M.D.)

Reviewed and approved as to form 7th day of FEBRUARY, 2002

FINDINGS OF FACT

1. The Board is the duly constituted authority for the regulation and control of the practice of allopathic medicine in the State of Arizona.

2. Respondent is the holder of license number 24075 for the practice of allopathic medicine in the State of Arizona.

Case No. MD-00-0370

3. The Board initiated case number MD-00-0370 upon receiving a complaint alleging that Respondent prescribed excessive and/or questionable amounts of controlled substances to several patients, wrote fraudulent prescriptions, and scheduled questionable surgeries for insurance purposes.

4. Board staff reviewed numerous patient records and prescription records obtained from local pharmacies. The records indicated that several patients, including patient S.N., D.U., and S.B., were receiving large amounts of controlled substances from Respondent.

5. Respondent treated patient S.N., a female patient who suffered from Gardner's Syndrome. Patient S.N.'s primary care physician referred her to Respondent for treatment of cysts in the genital area. For approximately two years, Respondent performed incision and drainage every 2 to 3 weeks under general anesthesia and prescribed over 6,000 dosage units of Hydrocodone with acetaminophen (Lortab).

6. Richard Zonis, M.D., Chief Medical Consultant, (Dr. Zonis) reviewed the case. Dr. Zonis expressed concern about Respondent prescribing increasing amounts of narcotic medications and subjecting patient S.N. to general anesthesia every 2 to 3 weeks for more than 2 years for a benign condition. Respondent did not initiate or record a dermatological consult and there is no record of a colonoscopy being recommended or performed in spite of the risk of colon cancer associated with Gardner's Syndrome.

Respondent fell below the standard of care in prescribing excessive amounts of medications to patient S.N.

7. Respondent treated patient D.U., a thirty-five year old female, who suffered from fibromyalgia. Respondent delivered patient D.U.'s baby on January 8, 2000. From April 2000 until August 2000 Respondent prescribed/refilled 1000 units of Hydrocodone 7.5 mg, 60 units Oxycontin 10mg, and 1060 units of Oxycontin 20 mg.

8. Dr. Zonis reviewed the case and concluded that Respondent's medical records regarding patient D.U. do not contain a history or physical examination concerning fibromyalgia and there were no specialist consultations. Additionally, the record was extremely sparse and unacceptable from the perspective of chronic pain management. Respondent fell below the standard of care in prescribing excessive doses of medicine and in maintaining inadequate medical records.

9. On November 11, 2001, Board staff conducted an investigational interview with Respondent. During the interview, Respondent answered questions about his care and prescribing practices in regards to several patients. Specifically, Respondent informed Board staff that he had never seen a patient with Gardner's syndrome prior to treating patient S.N., and he believed there was a risk associated with frequent induction of general anesthesia, but he did not perform liver function tests on patient S.N.

10. Respondent also discussed his treatment of patient D.U. Respondent admitted that he did not check her liver functions regularly with respect to the acetaminophen she received. Respondent also admitted that he did not obtain any prior physician's records regarding the original diagnosis of fibromyalgia and only assessed the patient by her symptoms and her own relaying of information.

11. Board staff specifically questioned Respondent about his prescribing practices in regards to patient S.B., who subsequently married Respondent on September

15, 2000. Respondent stated that he did not prescribe any controlled substances to patient S.B. after they were married.

12. On November 13 and 27, 2001, Board staff obtained pharmacy records from several pharmacies. The pharmacy records indicated a number of prescriptions for controlled substances written or authorized for patient S.B. by Respondent after their marriage date of September 15, 2000.

13. Specifically, the records show that, after the date of marriage, Respondent signed, issued, or called in 14 controlled substance prescriptions for patient S.B. Dr. Zonis, Chief Medical Consultant, reviewed the case and concluded that if patient S.B. was not addicted before she became a patient of Respondent, as a result of his prescribing practices, she certainly became addicted while under his care.

14. Respondent fell below the standard of care in his prescribing of controlled substances to patients S.N. and D.U. Respondent committed unprofessional conduct in providing false information to the Board and in prescribing controlled substances to patient S.B., a member of his immediate family.

Case No. MD-00-0546

15. The Board initiated case number MD-00-0546 upon receiving information of a malpractice settlement.

16. On January 7, 1998, patient C.H., a thirty-four year old pregnant female, reported to the Emergency Room at Navapache Regional Medical Center with complaints of nausea and vomiting. Patient C.H.'s blood pressure was 80/60 and she was hypothermic on admission.

17. Bruce Hall, M.D. (Dr. Hall) was the emergency room physician. Dr. Hall admitted patient C.H. and diagnosed nausea and vomiting secondary to pregnancy. Dr. Hall referred patient C.H. to Respondent, the on-call obstetrician. Respondent continued

the symptomatic treatment. Twelve hours after admission, patient C.H. was found dead in her hospital bed.

18. Joseph Buxer, M.D. (Dr. Buxer), Board Medical Consultant, reviewed the file and concluded that patient C.H. may have died of an acute peripartum cardiomyopathy, a rare illness. Dr. Buxer further stated that it is entirely unreasonable to expect an obstetrician/gynecologist to immediately recognize and diagnose this condition. However, in light of patient C.H.'s pregnancy, a fetal monitor strip followed by a phone call to the on-call perinatologist would have demonstrated critical awareness.

19. Accordingly, Respondent failed to properly evaluate patient C.H.'s signs and symptoms.

Case No. MD-01-0455

20. The Board initiated case number MD-01-0455 after obtaining medical records from Navapache Regional Medical Center in regards to another investigation.

21. Respondent saw patient W.H., a seventy-three year old female patient, on September 21, 1998, for postmenopausal bleeding. During the examination, Respondent observed a very large neoplastic mass growing out of her cervix.

22. Respondent biopsied the mass, but did not complete the pelvic examination. Due to Respondent's failure to continue the pelvic examination, he failed to diagnose Stage 3 cancer, which should only be treated by radiation therapy and not surgery.

23. On October 2, 1998, Respondent proceeded to perform a total abdominal hysterectomy. During the procedure, Respondent cut across the tumor and injured the ureters, necessitating further surgical repair.

24. Dr. Buxer, Board Medical Consultant, reviewed the file and noted that Respondent failed to complete the pelvic examination, failed to classify the stage of cancer, failed to consult a gynecological oncologist to determine if surgery was

appropriate. Dr. Buxer, also reviewed seven additional patient charts and noted that none of the charts contained a formal history and physical examination, as required for major surgery.

25. Respondent fell below the standard of care in failing to properly stage the cancer, failing to obtain a gynecological oncologist consult, and in performing surgery that cut across the tumor and obstructed both ureters, and surgery that was contraindicated in Stage 3 cancer of the cervix.

Case No. MD-01-0687

26. The Board initiated case number MD-01-0687 after receiving a letter of complaint regarding Respondent's failure to respond to a call while on-call.

27. On September 22, 2001, Respondent was on-call at Navapache Regional Medical Center. Hospital staff attempted to contact Respondent for a patient in need of an urgent evaluation of moderate fetal distress

28. Respondent did not respond to the call and had made no arrangements for coverage during his absence. Respondent had been involved in a similar incident within the past year at Navapache Regional Medical Center.

29. On October 15, 2001, the Board received a narrative response from Respondent, who stated that he was not on-call for all emergencies but only for "unassigned patients and transfers from Whiteriver Indian Hospital." The patient in need of the evaluation on September 22, 2001 was not an unassigned patient or transfer. Thus, he felt comfortable leaving town for a couple of hours knowing that the primary care physician would refer the evaluation to another obstetrician/gynecologist.

30. Richard Zonis, M.D., Chief Medical Consultant, reviewed the case and the Navapache Regional Medical Center bylaws. According to the bylaws, an on-call physician must respond to a call within 60 minutes of receipt and if the physician knows

within 24 hours in advance of his inability to be on-call, the physician must provide alternative coverage. Respondent neither responded nor provided alternative coverage.

31. Respondent's failure to respond to the call and his failure to provide coverage falls below the acceptable standard of care.

CONCLUSIONS OF LAW

1. The Board possesses jurisdiction over the subject matter hereof and over Respondent.

2. The conduct and circumstances described above in paragraphs 4 to 13 constitute unprofessional conduct pursuant to A.R.S. § 32-1401(25)(j) ("[p]rescribing, dispensing or administering any controlled substance or prescription-only drug for other than accepted therapeutic purposes.")

3. The conduct and circumstances described above in paragraphs 4 to 13, 16 to 18, 21 to 24, and 27 to 30 constitutes unprofessional conduct pursuant to A.R.S. § 32-1401(25)(q) ("[a]ny conduct or practice which is or might be harmful or dangerous to the health of the patient or the public.")

4. The conduct and circumstances described above in paragraphs 11 to 13 constitutes unprofessional conduct pursuant to A.R.S. § 32-1401(25)(h) ("[p]rescribing or dispensing controlled substances to members of the physician's immediate family ")

5. The conduct and circumstances described above in paragraphs 11 to 13 constitutes unprofessional conduct pursuant to A.R.S. § 32-1401(25)(jj) ("[k]nowingly making a false or misleading statement to the board or on a form required by the board or in a written correspondence, including attachments, with the board.")

6. The conduct and circumstances described above in paragraphs 16 to 18 constitute unprofessional conduct pursuant to A.R.S. § 32-1401(25)(l) ("[c]onduct that the

board determines is gross malpractice, repeated malpractice or any malpractice resulting in the death of a patient. ")

7. The conduct and circumstances described above in paragraphs 16 to 18 constitute unprofessional conduct pursuant to A.R.S. § 32-1401(25)(ll) ("[c]onduct that the board determines is gross negligence, repeated negligence or negligence resulting in harm to or death of a patient.")

8. The conduct and circumstances described above in paragraph 8 constitute unprofessional conduct pursuant to A.R.S. § 32-1401(25)(e)("[f]ailing or refusing to maintain adequate patient records on a patient.")

ORDER

IT IS HEREBY ORDERED THAT:

1. Respondent is issued a Decree of Censure for the conduct described above.

2. Respondent's license is revoked. However, the revocation is stayed and Respondent is placed on probation for 5 years with the following terms and conditions. Upon any violation of a probationary term, after giving notice and the opportunity to be heard, the Board shall terminate the probation and revoke Respondent's license. If an investigation involving an alleged violation of the probation is initiated, but not resolved prior to the termination of the probation, the Board shall have continuing jurisdiction and the period of probation shall extend until the matter is final.

(A) Respondent shall pay a fine in the amount of $ 2,500.00. Respondent shall pay the fine within 60 days of the effective date of this Order.

(B) Respondent shall, within one year of the effective date of this Order, obtain 15 hours of Board staff pre-approved Category I CME in gynecological oncology, 20 hours of Board staff pre-approved Category I CME in prescribing controlled substances and 20 hours of Board staff pre-approved Category I

CME in pain management. Respondent shall provide Board staff with satisfactory proof of attendance. The CME hours shall be in addition to the hours required for the biennial renewal of medical license.

(C) Respondent shall not prescribe, administer or dispense any Schedule II and III controlled substances. After one year from the effective date of this Order, Respondent may apply to the Board for its affirmative written permission to prescribe, administer, and dispense Schedule II and III controlled substances.

(D) Respondent shall not practice pain management until he applies to the Board and affirmatively receives the Board's affirmative written approval to do so.

(E) Respondent shall adhere to the hospital's on-call schedule. The Board should be notified of a violation of this probationary term.

(F) Respondent shall immediately provide a copy of this Order to all hospitals where Respondent has any privileges to practice. Within thirty (30) days of the effective date of this Order, Respondent is further required to provide the Board with the name(s) of the hospitals where he has privileges to practice and a signed statement that he has complied with this notification requirement.

(G) Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Board, stating whether there has been compliance with all the conditions of probation. The declarations shall be submitted on or before the 15th of March, June, September and December of each year.

3. The Board retains jurisdiction and may initiate new action based upon any violation of this order.

4. This Order is the final disposition of case numbers MD-00-0546, MD-00-0370, MD-01-0455, and MD-01-0687.

DATED AND EFFECTIVE this 6th day of March, 2002.

(SEAL)

BOARD OF MEDICAL EXAMINERS
OF THE STATE OF ARIZONA

By Claudia Foutz
CLAUDIA FOUTZ, Executive Director

ORIGINAL of the foregoing filed this 6th day of March, 2002 with:

The Arizona Board of Medical Examiners
9545 E. Doubletree Ranch Road
Scottsdale, AZ 85258

EXECUTED COPY of the foregoing mailed by Certified Mail this 6th day of March 2002 to:

Daniel Jantsch, Esq.
Olson, Jantsch, Bakker & Blakey, P.A.
7243 N. 16th St.
Phoenix, AZ 85020-5203

EXECUTED COPY of the foregoing mailed by this 6th day of March, 2002 to:

Bruce Hunter, M.D.
P.O. Box 1809
Lakeside, AZ 85929

L.A. Lloyd, Executive Director
4425 W. Olive Ave., Ste. 140
Glendale, AZ 85302-3844

Barbara Roberts
Drug Enforcement Administration
3010 North 2nd Street, Ste. 301
Phoenix, AZ 85012

EXECUTED COPY of the foregoing hand-delivered this 6th day of March, 2002, to:

Christine Cassetta, Assistant Attorney General
Sandra Waitt, Management Analyst
Lynda Mottram, Compliance Officer
Lisa Maxie-Mullins, Legal Coordinator (Investigation File)
c/o Arizona Board of Medical Examiners
9545 E. Doubletree Ranch Road
Scottsdale, AZ 85258

BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of **BRUCE C. HUNTER, M.D.** Holder of License No. **24075** For the Practice of Allopathic Medicine In the State of Arizona.	**MD-03-C090A** **AMENDMENT TO CONSENT AGREEMENT AND ORDER OF CENSURE AND PROBATION DATED MARCH 6, 2002.**

This matter was considered by the Arizona Medical Board ("Board") at its public meeting on June 11, 2003. The Board was presented with the request of Bruce C. Hunter, M.D., ("Respondent") to amend a March 6, 2002 Consent Agreement and Order ("Consent Agreement") restricting Respondent's practice by prohibiting him from prescribing, administering or dispensing Schedule II and III Controlled Substances and from practicing pain management. The Consent Agreement provided that Respondent could request that the Board lift the prescribing restriction after one year and that the restriction on pain management was in place until further order of the Board. The terms and conditions of the Consent Agreement are incorporated herein by reference. After due consideration of the facts and law applicable to this matter, the Board voted to amend the March 6, 2002 Order by issuing the following Order.

ORDER

IT IS HEREBY ORDERED that:

1. Respondent is no longer prohibited from prescribing, administering or dispensing Schedule II and III controlled substances.

DATED this 11th day of June, 2003.

ARIZONA MEDICAL BOARD

By _____
BARRY A. CASSIDY, Ph.D., PA-C
Executive Director

ORIGINAL of the foregoing filed this 12th day of June, 2003 with:

The Arizona Medical Board
9545 East Doubletree Ranch Road
Scottsdale, Arizona 85258

Executed copy of the foregoing mailed by U.S. Certified Mail this 12th day of June, 2003, to:

Bruce C. Hunter, M.D.
PO Box 1809
Lakeside, Arizona 85929-1809

Copy of the foregoing hand-delivered this 12th day of June, 2003, to:

Christine Cassetta
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Sandra Waitt, Management Analyst
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Scottsdale, Arizona 85258